LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

200 W. Washington, Suite 301
Indianapolis, IN 46204
(317) 233-0696
http://www.in.gov/legislative

FISCAL IMPACT STATEMENT

LS 7445
BILL NUMBER: HB 1537

NOTE PREPARED: Jan 23, 2007
BILL AMENDED:

SUBJECT: Indiana Health Care Program.

FIRST AUTHOR: Rep. Reske
FIRST SPONSOR:

BILL STATUS: As Introduced

FUNDS AFFECTED: X **GENERAL**
X **DEDICATED**
FEDERAL

IMPACT: State & Local

Summary of Legislation: *Indiana Health Coverage Program:* The bill provides a tax credit for certain small employers. The bill creates a health care program administered by a Health Care Corporation to provide health coverage for all residents. It allows the Corporation to adopt emergency rules effective until sine die adjournment of the succeeding General Assembly if the Corporation determines implementation of the program according to the statute is impossible. The bill requires all residents to have health coverage. The bill also makes an appropriation.

Medical Expenses for Adopted Children: The bill requires payment by the county office of family and children or the Department of Child Services of the costs of certain health-related adoption subsidies. It makes a determination by the Department of Child Services with respect to subsidies subject to administrative review.

Effective Date: July 1, 2007; January 1, 2008.

Summary of Net State Impact: The potential impact of the Indiana Health Coverage Program to the state General Fund is summarized in the table below.

	FY 2008	FY 2009	FY 2010
Premium Assistance Payments	$0	$1,575 M	$2,100 M
Small Employer Health Benefit Tax Credit	0	65 M - 155 M	65 M - 155 M
Indiana Health Coverage Corporation Operations	5 M	5 M	5 M
Total	$5 M	$1,645 M - $1,735 M	$2,170 M - $2,260 M

Explanation of State Expenditures: *Indiana Health Coverage Corporation:* The bill establishes the Indiana Health Coverage Corporation (IHCC) as a body corporate and politic, not a state agency but a public instrumentality performing an essential public function. The purpose of the IHCC is to facilitate the availability and choice of, and coverage under, a health benefit plan for eligible individuals and eligible small employer groups (employers with 2 to 50 employees). Based on its responsibilities and the potential size of the population that the IHCC will serve, the personnel cost of the IHCC could potentially total about $5 M annually. This estimate is based staffing table, salary, and estimated benefit totals for the Office of Medicaid Policy and Planning.

The IHCC is governed by a board consisting of 11 members who must be Indiana residents. The members are as follows:

(1) The Secretary of Family and Social Services, who serves as chairperson.
(2) The Director of the Office of Medicaid Policy and Planning.
(3) The Commissioner of the Department of Insurance.
(4) The Commissioner of the Department of State Revenue.
(5) The Commissioner of the State Board of Accounts.
(6) Six members appointed by the Governor.

Members to be appointed by the Governor are to include an actuary, a health economist, a representative of small employers, an employee health benefit specialist, a representative of a health consumer organization, and a representative of organized labor. No more than three of these members may be members of the same political party, and none of these members may be employed by an insurance carrier. These members are appointed to three-year terms. Members who are state employees are entitled to reimbursement for traveling expenses and other expenses actually incurred in connection with the member's duties. Members who are not state employees are entitled to a minimum salary per diem of $50 per day and to reimbursement for traveling expenses and other expenses actually incurred in connection with the member's duties.

The IHCC Board is required to appoint an executive director to administer, manage, and direct the Indiana Health Coverage Program and the employees of the IHCC under the direction of the IHCC Board. The executive director is authorized by the bill to hire employees necessary to carry out the operation of the Indiana Health Coverage Program. The bill requires the IHCC to fulfill various duties, including the following:

(1) Establishing a process for authorizing eligible health benefit plans to be offered through the Indiana Health Coverage Program for procurement of eligible health benefit plan coverage to begin not later than October 1, 2008.
(2) Establishing a standardized application form and a process for determinations of eligibility for

participation in the Program, appeals of eligibility determinations; and enrollment of eligible individuals and eligible small employer groups.
(3) Establishing a process for annual corporation determinations concerning availability of affordable minimum coverage for residents.
(4) Establishing a process to provide residents, employers, and enrollees with information concerning the Program, including eligibility requirements and enrollment procedures.
(5) Managing Program enrollment.
(6) Establishing a process for management of a premium payment and collection system for payments made by or on behalf of enrollees, including premium assistance payments made by the state to authorized health benefit plans on behalf of eligible enrollees.
(7) Creating and providing to the Department of State Revenue (DOR) a form for distribution to each individual to whom the DOR distributes information regarding individual Adjusted Gross Income Tax liability, including each individual who filed an Adjusted Gross Income Tax return during the most recent calendar year, informing the individual of the requirement that each individual resident establish and maintain health coverage.
(8) Creating and publishing, before September 30 of each year, a program enrollee premium rate schedule.

Indiana Health Coverage Program: Minimum Coverage Requirement: The bill requires every Indiana resident who is 18 years old (and 63 days) or older to maintain "minimum coverage" for himself or herself and any resident dependents, unless the lack of coverage is due to the resident's sincerely held religious beliefs. The bill also requires a resident filing an Adjusted Gross Income (AGI) Tax return to indicate on the return whether the resident complied with the minimum coverage requirement. A resident who claims the exemption from the coverage requirement but who receives or whose dependents receive health care services during the taxable year are liable for full payment of charges for these services and is subject to a penalty (imposed by the DOR) equal to 100% of the minimum premium for minimum coverage for each month of noncompliance. A resident is not liable for the penalty if noncompliance with the coverage requirement is for fewer than 64 days. The minimum coverage requirement begins on October 1, 2008. The bill defines "minimum coverage" as coverage for all of the following (not including worker's compensation coverage) under a health benefit plan:

(1) Preventive care.
(2) Inpatient and outpatient hospital and physician care.
(3) Diagnostic laboratory care.
(4) Diagnostic and therapeutic radiological services.
(5) Emergency care.
(6) Mental health services.
(7) Services for alcohol and drug abuse.
(8) Dental services.
(9) Vision services.
(10) Long-term rehabilitation treatment.
(11) Health care services required under state or federal law.

State-Subsidized Health Coverage: The bill establishes the Indiana Health Coverage Program to provide health care coverage to eligible residents and small employer groups not later than October 1, 2008. The bill prohibits an eligible resident or small employer group from being denied coverage under a health benefit plan offered under this Program. It is estimated that about 95,000 single individuals and 166,000 families could potentially be eligible for subsidized health care coverage through the Program. The cost of the subsidy is estimated at about $2,100.0 M per year, with the potential for 5% to 10% annual growth in premium cost.

This would be an average premium subsidy of almost $8,046, assuming the average annual premium for single coverage is $4,500 and for family coverage is $11,500. (Note: Assuming an October 1, 2008, start date, the cost in FY 2008 is estimated at $1,575.0 M.) An Indiana resident is eligible to obtain coverage under the Program if:

(1) the resident is not eligible for coverage under a state or federal health coverage program;
(2) the resident does not have coverage under an individual or a group health benefit plan available to the resident; and
(3) the resident or resident's family member has not accepted a financial incentive from an employer to decline coverage under the employer's employer-sponsored health benefit plan.

Eligible residents whose family income exceeds 300% of the federal poverty level (FPL) pay 100% of the premium for health coverage obtained under the Program. Eligible residents whose family income is at or below 300% of the FPL would receive premium assistance payments from the state to pay a portion of the premium cost. The bill requires the premium contribution from an eligible resident to be not more than: (1) 10% of family income for residents whose family income is more than 200% of the FPL but not more than 300% of the FPL; and (2) 5% of family income for residents whose family income is 200% of the FPL or less.

The bill requires an insurance carrier that is regulated by the Department of Insurance and provides health care coverage to Indiana residents through either an individual or a small employer group policy to submit to the IHCC a health benefit plan that meets the minimum coverage criteria defined in the bill and criteria established by the IHCC for an eligible health benefit plan under the Program. The eligible health benefit plan must provide for:

(1) an annual deductible of $1,000 and annual maximum out-of-pocket payment by the resident equal to $5,000 for family coverage and $2,500 for individual coverage, if the resident's family income exceeds 300% of the FPL; and
(2) an annual deductible of $500 and annual maximum out-of-pocket payment by the resident equal to $1,000 for family or individual coverage, if the resident's family income is 300% of the FPL or less.

The bill also specifies other criteria for a health benefit plan to be authorized by the IHCC, including criteria regarding the premium rating method for the health benefit plan; a nondiscrimination requirement; and a requirement that the health benefit plan cover employees of eligible small employers. For purposes of small employer group coverage under the Program, a "small employer" is defined as an employer with 2 to 50 employees. Eligible small employer groups may obtain health coverage through the Program, but premium costs are shared entirely between the employer and employees with no premium assistance payments being made by the state for such coverage.

Indiana Health Care Coverage Trust Fund: The bill establishes the Indiana Health Coverage Trust Fund which is nonreverting and administered by the IHCC. Money in the Fund is to pay for the operations of the IHCC and the Indiana Health Coverage Program. The bill requires money received by the IHCC from taxes, appropriations, donations, penalties, fees, surcharges, or another source to be deposited in the Fund. The bill provides for an annual appropriation to the Fund from the state General Fund of an amount necessary to operate the Indiana Health Coverage Program.

A noncode section of the bill requires the Office of Medicaid Policy and Planning to apply to the U.S. Department of Health and Human Services (HHS) for a demonstration waiver to allow coverage for

minimum health care coverage under the Indiana Health Coverage Program for non-elderly Indiana residents with incomes less than 300% of the FPL. The application for the waiver must be made before September 1, 2007. The potential impact of this provision is indeterminable and depends on actions by HHS.

Estimation Methodology: Survey research by the Urban Institute and the Kaiser Family Foundation estimates that about 860,000 non-elderly Indiana residents are uninsured, with about 512,000 of this total estimated to have incomes below 200% of the FPL. The research estimates that the balance of this group (about 348,000 non-elderly Indiana residents) have incomes of 200% of the FPL or higher. Based on U.S. Census Bureau estimates of the population income distribution in Indiana, it is estimated that about 86,000 persons from this second group have incomes between 200% and 300% of the FPL. Thus, the total uninsured population with incomes of 300% of the FPL or below is estimated to total about 599,000. U.S. Census estimates of the distribution of persons living alone and in family units suggest that about 75% to 80% of this total could potentially be living in family units, with the balance living alone. As a result, it is estimated that this population could potentially generate about 95,000 single-coverage policies and potentially 166,000 family-coverage policies. Assuming an average annual premium cost of $4,500 for single coverage and $11,500 for family coverage, the annual cost of premium assistance payments for these uninsured individuals and families could potentially total about $2,100.0 M. The average premium costs are estimates for 2006 based on survey research regarding employer-provided health coverage conducted annually by the Kaiser Family Foundation. The estimate also assumes that premium contributions are set by the Indiana Health Coverage Corporation at the maximum levels provided by the bill (see above under State-Subsidized Health Coverage).

Department of State Revenue: The DOR would incur significant additional administrative expenses relating to the Indiana Health Coverage Program. Under the bill, the DOR is required to distribute information to individual income taxpayers regarding the requirement that all residents must establish and maintain minimum health coverage. In addition, the DOR would have to revise individual tax returns and instructions for individual taxpayers to indicate on the return whether the taxpayer has established and maintained minimum health coverage during the year. In addition, the DOR would have to administer penalties imposed on individuals who have not complied with the minimum health coverage requirement.

The DOR also would incur some administrative expenses relating to the revision of tax forms, instructions, and computer programs to incorporate the new tax credit for employer health benefit costs.

The funds and resources required above could be supplied through a variety of sources, including the following: (1) existing staff and resources not currently being used to capacity; (2) existing staff and resources currently being used in another program; (3) authorized, but vacant, staff positions, including those positions that would need to be reclassified; (4) funds that, otherwise, would be reverted; or (5) new appropriations. Ultimately, the source of funds and resources required to satisfy the requirements of this bill will depend upon legislative and administrative actions. The January 1, 2007, state vacant position report indicates that the DOR currently has 235 vacant full-time positions.

Medical Expenses for Adopted Children: If the county Department of Child Services office does not have adequate funding to pay for the medical subsidy, the Department of Child Services shall pay. The cost to the state for this coverage is dependent upon the ability of the county Department of Child Services offices to pay. Total cost is not known. (See *Explanation of Local Expenditures*.)

Explanation of State Revenues: *Small Employer Health Benefit Tax Credit:* The bill would reduce state Adjusted Gross Income Tax, Financial Institutions Tax, and Insurance Premiums Tax liabilities of taxpayers

employing 2 to 50 persons (defined by the bill as a small employer) for costs of providing a health benefit plan to their employees. The revenue loss attributable only to small employers that currently provide health benefits to their employees is estimated to total about $65 M to $155 M annually beginning FY 2009. (Note: Carryover of credits that taxpayers can't exhaust against tax liability could potentially total $400 M to $500 M annually.)

Background: (Revised) The bill establishes a nonrefundable AGI Tax credit equal to 50% of the costs incurred by a small employer during the taxable year for coverage under a health benefit plan provided to employees during the taxable year. Credits exceeding a taxpayer's AGI Tax liability may be carried forward to succeeding taxable years. Excess credits are not refundable and may not be carried back.

Estimates using County Business Patterns employer data and annual survey research by the Kaiser Family Foundation estimating the prevalence and cost of employer-provided health benefits suggests that there could potentially be 44,000 to 45,000 firms in Indiana employing 2 to 50 employees and providing health benefits. The survey research suggests that the preponderance of firms pay at least 50% of the premium cost for these health benefits and that the preponderance of employees offered health benefits participate in the benefit program. Credit estimates are based on estimated average single- and family-coverage premiums reported for employer-provided benefit programs in 2006 ($4,248 for single coverage and $11,306 for family coverage). The estimates also assume that, on average, firms have a net tax liability ranging from $1,500 to $3,500.

Since the bill is effective beginning in tax year 2008, the fiscal impact could potentially begin in FY 2009. The revenue from the individual AGI Tax is deposited in the state General Fund (86%) and the Property Tax Replacement Fund (14%).

Explanation of Local Expenditures: *Medical Expenses for Adopted Children:* This bill requires the county Department of Child Services office to pay a medical subsidy for an adoptive child with a pre-existing medical condition. Total cost to county Department of Child Services offices statewide is estimated to be $117,000 for the first year. The cost of medical services for this group may be higher or lower than this number based upon several factors: (1) number of children adopted who have pre-existing conditions, (2) number of adopted children that do not have insurance - either due to the adoptive parent being uninsured or the insurance not covering pre-existing conditions, and (3) cost to provide medical services for the pre-existing condition to the adoptive child (depends upon the amount of the subsidy granted).

Background Information: The existing program requires that the medical costs of special needs adoptions be paid through Medicaid with a mix of county and state matching funds. In addition, some children with pre-existing conditions receive medical subsidies under certain circumstances. However, current medical subsidies are paid exclusively by the county Office of Child Services and are limited by the amount of funding available.

The total number of children adopted with pre-existing conditions is unknown. There have been 3,065 children adopted the last three years in Indiana.

Number of Children Adopted FY 2004 through FY 2006 and Estimated Health Insurance Status.

Year	Number Adopted	Employer Insured (62%)*	Individual Insured (4%)*	Medicaid/Medicare Insured (24%)*	Uninsured (9%)*
2004	1,054	653	42	253	95
2005	979	607	39	235	88
2006	1,032	640	41	248	93
Total	**3,065**	**1,900**	**123**	**736**	**276**
Average	**1,022**	**633**	**41**	**245**	**92**

Notes: #Preliminary data; *Estimates based upon percent coverage by insurer type 2003-2004 data.

This bill states that the county Office of Child Services is required to pay a subsidy for the medical, surgical, hospital, and related expenses for an adoptive child due to a pre-existing physical, mental, emotional, or medical condition of the child if state or local government paid for treatment prior to adoption and payments from insurance or public money to treat the condition are not available to the child or parents. It is unknown the number of children who are adopted that do not have insurance or insurance coverage for a condition. Due to exclusions for pre-existing conditions, some children who are insured under a family coverage may not have full coverage for a condition. The amount of each subsidy is contingent upon what is required in the court order or adoption decree. Thus, the subsidy cost per child is unknown.

For this analysis the estimated number of children requiring insurance under the provisions of this bill is 92. This number is based upon statistics of child insurance coverage status and the number of children adopted through the Department of Child Services in the past three years. This assumes that 9% of children do not have insurance (based upon the state average of uninsured children). This estimate represents the number of children adopted each year that do not have insurance. However, this number may be different from the number of children covered by the provisions of this bill as this bill only requires subsidies for pre-existing conditions. In addition, due to the ongoing nature of this provision, more children would be added each year until a maximum point was reached.

The cost of services provided under the CHIP program is $106 per member per month. (*Note*: This is an average of costs applicable to preschool, children, and teenager CHIP categories.) Using this number as an estimate, the cost to pay for medical expenses of adopted children is approximately $1,272 per child per year. Total estimated cost to county Office of Child Services would then be $117,024 for the first year. Total cost may be higher or lower than this estimate depending upon the amount of subsidy required in the court order or adoption decree. The cost to the county and state may increase each year as more children are adopted and granted medical subsidies. The provisions of this bill require that the medical subsidy be paid until the child turns 18, is emancipated, dies, the adoption is terminated, or further order of the court.

The total state and county general fund expenditures for FY 2006 for medical expenses of adopted children were $30.4 M. These funds receive a federal Medicaid reimbursement of about 63%, or $19.2 M. The number of children receiving these services is not known at this time. It should be noted that these dollars are not limited to special needs adoptions. In addition, they include medical assistance provided for all adopted children in which a court decree ordered the state to provide assistance after the completion of the

adoption.

Explanation of Local Revenues:

State Agencies Affected: Department of State Revenue; Department of Insurance; State Board of Accounts; Family and Social Services Administration; Office of Medicaid Policy and Planning; Department of Child Services; Governor's Office.

Local Agencies Affected: County Department of Child Services offices.

Information Sources: OFMA Corporate and Individual Income Tax databases, 2002-2004; Kaiser Family Foundation, *Employer Health Benefits 2006 Annual Survey*, available at http://www.kff.org and *State Health Facts Online* available at http://www.statehealthfacts.kff.org/; Bureau of the Census, *County Business Patterns, 2004;* Sharon Eichman, Department of Child Services; Cassandra Porter, Department of Child Services; John Ryan, Department of Child Services; Pat Casanova, Family and Social Services Administration; Mike Fowler, Office of Medicaid Policy and Planning.

Fiscal Analyst: Jim Landers, 317-232-9869.